# Medical History Form

Premed Needed?
Reason:

Date: _____

Schutze Family Dentistry

Name: _____ Name You Prefer to Be Called:_____
Birth Date: _____ Ht:_____ Wt:_____ SS#:_____
Address: _____Ph (H#)_____(C#)_____
Employer: _____W(#)_____Email:_____
Any Physical Limitations: Handicap... Eye Problems...Difficulty Hearing...Other:_____
Who to Contact in an Emergency: _____ Relation: _____ Ph#_____

**Do You Have or Ever Had Medical Conditions Involving the Following:** (Please Circle Any that Apply)

**Allergies** (Please List Allergies)

| | | |
|---|---|---|
| Food Allergies | Yes | No |
| Drug Allergies (List Existing Allergies Below) | Yes | No |
| _____ _____ _____ | | |
| _____ _____ _____ | | |
| Dental Anesthesia | Yes | No |

**Heart/ Blood Vessels**

| | | |
|---|---|---|
| AIDS/HIV | Yes | No |
| Angina/Chest pains | Yes | No |
| Artificial Valve | Yes | No |
| High Cholesterol | Yes | No |
| Heart Murmur? Yes No/Need Premed? | Yes | No |
| Blood Transfusion | Yes | No |
| Heart Attack/Heart Failure | Yes | No |
| Pace Maker/ Atrial Fibrillation | Yes | No |
| Heart Disease/ Endocarditis | Yes | No |
| High or Low Blood Pressure | Yes | No |
| Irregular Heart Beat | Yes | No |
| Mitral Valve Prolapse | Yes | No |
| Shortness of Breath | Yes | No |
| Heart Related Surgeries | Yes | No |

**Blood**

| | | |
|---|---|---|
| Blood Disease | Yes | No |
| Lyme Disease | Yes | No |
| Anemia | Yes | No |
| Taking Blood Thinners | Yes | No |
| Excessive Bleeding/Clotting | Yes | No |
| Hemophilia | Yes | No |
| Bruise Easily | Yes | No |

**Neurological**

| | | |
|---|---|---|
| Stroke | Yes | No |
| Frequent Headaches | Yes | No |
| Seizures/Convulsions | Yes | No |
| Fainting Spells/Dizziness/Vertigo | Yes | No |

**Muscles and Bones**

| | | |
|---|---|---|
| Arthritis | Yes | No |
| Gout | Yes | No |
| Artificial Joint? Yes No /Need Premed? | Yes | No |
| Osteoporosis/Osteopenia | Yes | No |
| Taking Bisphosphonates | Yes | No |

(e.g. Fosamax, Actonel, Boniva)

**Respiratory**

| | | |
|---|---|---|
| Asthma/Breathing Problems | Yes | No |
| COPD | Yes | No |
| Sinus Problems | Yes | No |
| Lung Disease | Yes | No |
| Emphysema | Yes | No |
| Tuberculosis | Yes | No |
| Frequent Cough | Yes | No |
| Difficulty Breathing Lying Down | Yes | No |
| Sleep Apnea | Yes | No |
| Loud Snoring | Yes | No |
| Acid Reflux/Taking Antacids Regularly | Yes | No |

**Endocrine**

| | | |
|---|---|---|
| Diabetes | Yes | No |
| Thyroid /Goiter/Graves Condition | Yes | No |
| Low or High Blood Sugar | Yes | No |

**Intestinal/Urinary System**

| | | |
|---|---|---|
| Hepatitis | Yes | No |
| Jaundice | Yes | No |
| Ulcers | Yes | No |
| Frequent Diarrhea | Yes | No |
| Genital Herpes | Yes | No |
| Kidney Disease | Yes | No |
| Venereal Disease | Yes | No |

**Cancer**

| | | |
|---|---|---|
| History of Tumor or Growth | Yes | No |
| Chemotherapy | Yes | No |
| Radiation Therapy | Yes | No |
| Catscan/MRI/Ultrasound | Yes | No |
| Cancer related Surgeries | Yes | No |

**Taking any of the following**

| | | |
|---|---|---|
| Steroids Within the Past 2 Years | Yes | No |
| Vitamins...Herbs...Supplements | Yes | No |
| Non-Prescription Drugs on Reg. Basis | Yes | No |

**Women Only**: Are You:

| | | |
|---|---|---|
| Pregnant or Nursing | Yes | No |
| Trying to Become Pregnant | Yes | No |
| Taking Hormones | Yes | No |
| Taking Birth Control Pills | Yes | No |
| Prone to Yeast Infection with Antibiotics | Yes | No |

Over

**Other** _____

| | | |
|---|---|---|
| Are You in Good Health? | Yes | No |
| Any Health Changes in the Last Year? | Yes | No |
| Recent Weight Gain or Loss? | Yes | No |
| Currently Under a Physician's Care? | Yes | No |
| Abuse of Drugs or Alcohol? | Yes | No |
| Depression/Psychiatric Care? | Yes | No |
| Tobacco Use...Amount (_____) | Yes | No |
| Interested in Quitting? | Yes | No |
| Ever Been Hospitalized? | Yes | No |

Other Surgeries or Conditions We Should Be Aware of? _____

_____

_____

Preferred Pharmacy _____

Primary Care Dr._____

Phone #_____

Last Medical Exam_____

**Current Prescription Drugs** (Do you have a list of medications? Yes No)

Name of Drug: Dose: Why:

_____

_____

_____

_____

_____

_____

## Dental Health History

(Please Circle All that Apply)

Purpose of Visit? _____

Previous Dentist? _____

Last Dental Visit? _____

What Was Done? _____

**Have You Had:** _____

| | | |
|---|---|---|
| Anxiety About Dentistry? | Yes | No |
| Anxiety About Needles or Blood? | Yes | No |
| Difficulty Getting Numb? | Yes | No |
| Serious Dental Problems? | Yes | No |
| *Explain*: | | |
| Satisfactory Dental Care? | Yes | No |
| *Explain*: | | |

**Do You Have**: _____

| | | |
|---|---|---|
| Pain? Where? | Yes | No |
| Bleeding When Brushing or Flossing? | Yes | No |
| Gums that Feel Tender or Swollen? | Yes | No |
| Lumps or Growths in Mouth or Neck? | Yes | No |
| Canker/Cold Sores? | Yes | No |
| Difficulty or Painful Swallowing? | Yes | No |
| Teeth Sensitive to Hot/Cold/Sweets? | Yes | No |
| Strong Gag Reflex? | Yes | No |

**Do You**: _____

| | | |
|---|---|---|
| Chew Only on One Side? | Yes | No |
| *Explain*: | | |
| Avoid Brushing Areas of Your Mouth? | Yes | No |
| *Explain*: | | |

| | | |
|---|---|---|
| Clench/Grind Your Teeth While Asleep? | Yes | No |
| Clench/Grind Teeth While Awake? | Yes | No |
| Eat Any of the Following Daily? | | |
| Lemons/Candy/Mints/Cough Drops | Yes | No |
| Sip Drinks Throughout the Day? | Yes | No |
| Drink Energy Drinks Frequently? | Yes | No |
| Actively Playing Musical Instruments? | Yes | No |

**Have You Had**: _____

| | | |
|---|---|---|
| Jaws that Feel Tired? | Yes | No |
| TMJ Jaw Therapy or Treatment? | Yes | No |
| Accident or Injury to Head and Neck? | Yes | No |
| *Explain*: | | |
| Migraines or Facial Pain? | Yes | No |
| Teeth Shifting or Loosened? | Yes | No |
| Persistent Dry Mouth? | Yes | No |

Anything Else We Should Know?

**Ever Had the Following Treatments**(Approx Dates)

Periodontal Surgery (Gums):

Oral Surgery (Extractions):

Orthodontics (Braces):

Endodontics (Root Canals):

Patient signature_____

(office use only) Last Updated

| Date | Initials | Date | Initials |
|---|---|---|---|
| | | | |
| | | | |